DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/17/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135  NAME OF PROVIDER OR SUPPLIER  WESTVIEW NURSING AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET A 1510 CI BEDFO	ONSTRUCTION  01  ADDRESS, CITY, STATE, ZIP ( LINIC DR  RD, IN47421	— CON	TE SURVEY MPLETED D/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000	State Licensure State Indiana State accordance with Survey Date: 12 Facility Number: Provider Number AIM Number: 1 Surveyor: Phillip Code Specialist At this Life Safe Westview Nursin Center was found Requirements for Medicare/Me	ty Code survey, ng and Rehabilitation d not in compliance with r Participation in aid, 42 CFR Subpart lafety from Fire, and the		D000	The creation and submit Plan of Correction does constitute an admission provider of any conclusion the statement of definition of any violation of regularities provider respectful that the 2567 Plan of Coconsidered the letter of allegation and requests survey review on or after the complex of the complex	not a by this ion set forth iciencies, or lation. Illy requests prrection be credible a post	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155135		(X2) MU A. BUIL		NSTRUCTION 01	(X3) DATE S COMPLI	ETED
		155135	B. WINC	_		12/20/20	)11
NAME OF P	ROVIDER OR SUPPLIER			STREET AI	DDRESS, CITY, STATE, ZIP CODE		
WESTVI	EW NURSING AND	REHABILITATION CENTER			RD, IN47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	'	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	COMPLETION DATE
	resident rooms of provided with sm facility has a cap census of 75 at the Quality Review by F Code Specialist-Med The facility was	n Cottage hall were noke detectors. The acity of 149 and had a ne time of this survey.  Robert Booher, Life Safety dical Surveyor on 12/29/11.  found not in compliance ntioned regulatory					
K0017 SS=E	walls constructed or resistance rating. partitions are only passage of smoke buildings, walls proceiling. (Corridor or underside of ceiling permitted by Code stations, waiting an activity spaces may under certain condictivity spaces may be by non-fire rated with sprinklered.) 19 Based on observational facility failed to careas was separated met an Exception # 1 Sp	arated from use areas by with at least ½ hour fire In sprinklered buildings, required to resist the In non-sprinklered operly extend above the walls may terminate at the gs where specifically In Charting and clerical reas, dining rooms, and ly be open to the corridor ditions specified in the Code. separated from corridors walls if the gift shop is fully 1.3.6.1, 19.3.6.2.1, 19.3.6.5 action and interview, the lensure 1 of 1 open use ted from the corridor, or 1. LSC 19.3.6.1, laces shall be permitted in area and open to the	K0	017	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set for in the statement of deficiencies, of any violation of regulation.  This provider respectfully request	th or	01/06/2012

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					INSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155135		LDING		12/20/2011	
			B. WIN		DDDEGG CITY GTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIE	8			ADDRESS, CITY, STATE, ZIP CODE		
\//EQT\/II	EW NITIDSING AND	REHABILITATION CENTER			LINIC DR RD, IN47421		
				<u> </u>	RD, IN47421	_	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	•	DATE	
		ed that the following			that the 2567 Plan of Correction	be	
		(a) The spaces are not			considered the letter of credible		
	used for patient	sleeping rooms, treatment			allegation and requests a post survey review on or after 1/6/12		
	rooms, or hazardous areas. (b) The corridors onto which the spaces open in				Survey review on or arter 1/0/12	•	
	the same smoke	compartment are					
	protected by an electrically supervised						
		e detection system in			K-017 Break Room Smoke Detect		
		18.3.4, or the smoke			Facility failed to ensure 1 c		
		·			open use areas for employ		
	compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance				was properly protected by automatic smoke detection		
					system.	•	
					system.		
					What corrective actions wi	II be	
		<del>-</del>			accomplished for these		
		ne entire space is arranged			residents found to have be	en	
		low direct supervision by			affected by the deficient		
	1	from a nurses' station or			practice?		
	• `	d) The space does not			No residents were specifical	ly	
	obstruct access t	o required exits. This			No residents were specifically affected by this finding.	iy	
	deficient practic	e could affect any resident			and other by time initiality.		
	using the Service	e corridor which is			How will you identify other		
	adjacent to the E	Employee Breakroom to			residents having the poten	tial	
	access an exit as	well as visitors and staff.			to be affected by the same		
					deficient practice and what		
	Findings include	<b>:</b>			corrective action will be ta	Kenr	
					No residents were specifical	lv	
	Based on observ	ation on 12/20/11 at 2:44			affected by this finding.		
		aintenance Supervisor, the			·		
	-	room on Service hall			What measures will be put	into	
		to the corridor. Exception			place or what systemic		
	_	_			changes you will make to		
	_	(c) of the Life Safety			ensure that the deficient practice does not recur?		
		9.3.6.1 was not met as			practice does not recur?		
	_	n area was not protected			An automatic smoke detecti	on	
	by an automatic	smoke detection system					
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	S81121	Facility I	D: 000060 If continuation	sheet Page 3 of 21	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155135		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  12/20/2011		
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE LINIC DR RD, IN47421	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)  device has been installed in		(X5) COMPLETION DATE
	facility staff from area such as a nu interview on 12/2 the Maintenance acknowledged th on Service hall n corridor without	low direct supervision by a continuously staffed rses' station. Based on 20/11 at 2:47 p.m. with Supervisor, it was the Employee Breakroom orth was open to the supervision from the ad was not protected by			area.  Maintenance Supervisor/Designee will be responsible to ensure comp through scheduled rounds.  How the corrective action( will be monitored to ensure deficient practice will not responsible to the corrective action)	liance s) e the	
	automatic smoke 3.1-19(b)				i.e., what quality assurance program will be put into pl  Maintenance Supervisor/Designee will be responsible to ensure comp through scheduled rounds ethirty days for a period of nit days. These rounds will be	e ace? liance each	
					reviewed by the facility Qua Assurance Program for pote action or follow-up.	-	
					This Plan of Correction constitutes our credible allegation of compliance wall regulatory requirements Our date of completion is: 1/6/12		
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	S81121	Facility II	D: 000060 If continuation	sheet Pag	ge 4 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A PHILLIPLIC 01			(X3) DATE SURVEY COMPLETED		
		155135	A. BUII B. WIN			12/20/20	
		REHABILITATION CENTER TATEMENT OF DEFICIENCIES	J. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE  LINIC DR  RD, IN47421  PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0018 SS=E	than required enclexits, or hazardou doors, such as the solid-bonded core resisting fire for at sprinklered building resist the passage impediment to the are provided with keeping the door of meeting 19.3.6.3.6.  Roller latches are regulations in all he Based on observations facility failed to doors entering Dinto their frames could affect 8 resorom next to Die visitors and staff.  Findings include Based on observation the tour at 1:20 per Maintenance Supentering Dietary latching device of could not latch in interview on 12/2 the Maintenance acknowledged the	prohibited by CMS lealth care facilities. lation and interview, the lensure 1 of 1 corridor lietary hall would latch laterated. This deficient practice liedents in the Main dining letary hall as well as letary hall would latch letary hall as well as letary hall as well as	K	0018	K-018 Corridor door entering Dietary service area should be latched into frame. Facility failed to ensure 1 or corridor door entering Dieta hall would latch into its fram What corrective actions will accomplished for these residents found to have be affected by the deficient practice?  Proper latching mechanism has been installed causing Dietar service door to be latched who closed.  How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be take Any residents in the main dir room will be positively affected	ary ne. I be en nas ry nen ital	01/06/2012

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THE LEAD	or condition	155135	A. BUILDING B. WING	01	12/20/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER		1510 CI	LINIC DR	
WESTVIE	EW NURSING AND	REHABILITATION CENTER	BEDFO	PRD, IN47421	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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	3.1-19(b)			now that the proper latching mechanism has been installe causing Dietary service door be latched when closed.	ed
				What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur?	into
				Proper latching mechanism been installed causing Dieta service door to be latched w closed. Maintenance Supervisor/Designee will be responsible to ensure compl through scheduled rounds.	ry hen
				How the corrective action(s will be monitored to ensure deficient practice will not re i.e., what quality assurance program will be put into pla	e the ecur,
				Maintenance Supervisor/Designee will be responsible to ensure compl through scheduled rounds enthirty days for a period of nin days. These rounds will be reviewed by the facility Qual Assurance Program for pote action or follow-up.	ach ety ity
				This Plan of Correction constitutes our credible allegation of compliance w	ith

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155135			LDING	NSTRUCTION  01	(X3) DATE ( COMPL 12/20/2	ETED	
	PROVIDER OR SUPPLIER EW NURSING AND	REHABILITATION CENTER		1510 CL	DDRESS, CITY, STATE, ZIP CODE LINIC DR RD, IN47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0027 SS=E	a 20-minute fire present least 1¾-inch thick Non-rated protective 48 inches from the permitted. Horizon with 7.2.1.14. Document of the permitted of the automatic closing 19.2.2.2.6. Swing to swing with egreen of required. 19 Based on observation facility failed to smoke barrier do the appropriate he door which must close first so both completely as a present of the same with an astragal tensure the door walways closes first so both completely as a present of the same with an astragal tensure the door walways closes first could affect 30 reforward and 24 results from the same with an astragal tensure the door walways closes first could affect 30 reforward and 24 results from the same with an astragal tensure the door walways closes first could affect 30 reforward and 24 results from the same walk and the same wa	moke barrier doors that e direction and equipped to have a coordinator to which must close first st. This deficient practice esidents on Moving residents on nerapy west including	KO	0027	K-027 Smoke barrier doors lacked closure coordinator Facility failed to ensure 1 or corridor doors were equipped with a closure coordinator ensure the door with the meastragal always closed first What corrective actions will accomplished for these residents found to have been affected by the deficient practice?  Coordinators have been instruction on this single set of smoke be doors.  How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taken to the coordinators have been instructed to the coordinators have been instructe	f 10 ed to etal t. I be en alled arrier	01/06/2012

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155135		LDING	NSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  12/20/2011	
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	 STREET A	ADDRESS, CITY, STATE, ZIP CODE LINIC DR RD, IN47421	
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TAG	p.m. with the Maset of smoke bar Rehabilitation The same equipped with a coordinator to all the door to close sets of smoke do the astragal door interview on 12/2 the Maintenance acknowledged the barrier doors lack	nintenance Supervisor, the rier doors leading into herapy west hall, which he direction and were metal astragal, lacked a low the astragal side of first. When tested these ors closed properly with closing first. Based on 20/11 at 12:33 p.m. with Supervisor, it was he aforementioned smoke ked a coordinator to with the metal astragal	TAG	"When tested these sets of smoke doors closed properly the astragal door closing first As such, no other residents waffected by the lack of coordinators on these doors.  What measures will be put it place or what systemic changes you will make to ensure that the deficient practice does not recur?  Maintenance Supervisor/Designee will be responsible to ensure complithrough scheduled rounds.  How the corrective action(s will be monitored to ensure deficient practice will not reive., what quality assurance program will be put into plathrough scheduled rounds eathirty days for a period of nine days. These rounds will be reviewed by the facility Quality Assurance Program for potentiation or follow-up.  This Plan of Correction constitutes our credible allegation of compliance will regulatory requirements. Our date of completion is:	with t." were  into  ance cur, ace?  ance ach ety tty ntial

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155135 12/20/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1510 CLINIC DR WESTVIEW NURSING AND REHABILITATION CENTER BEDFORD, IN47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 1/6/12 One hour fire rated construction (with 3/4 hour K0029 fire-rated doors) or an approved automatic fire SS=E extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the K0029 01/06/2012 K-029 Door closure required for housekeeping storage room facility failed to ensure 1 of 3 doors Facility failed to ensure 1 of 3 leading to hazardous areas such as rooms storage room doors were with combustible items were provided equipped with a proper door with self closing devices which would closure. cause the door to automatically close and What corrective actions will be latch into the door frame. This deficient accomplished for these practice affects 8 residents observed in the residents found to have been Activities room which is next to the affected by the deficient Service corridor as well as visitors and practice? staff The proper door closure has been installed on the door of this Findings include: storage room. Based on observation on 12/20/11 at 1:45 How will you identify other residents having the potential p.m. with the Maintenance Supervisor, the to be affected by the same corridor door to the Housekeeping room deficient practice and what on Service hall which was larger than 50 corrective action will be taken? square feet in size, next to the Activities room, had twenty five cardboard boxes The proper door closure has been installed on the door of this without a self closing device on the storage room. There are no corridor door. Based on interview on residents using the employee 12/20/11 at 1:28 p.m. with the service hall, thus no other

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	PROVIDER OR SUPPLIE	REHABILITATION CENTER	151	EET ADDRESS, CITY, STATE, ZIP CODE 0 CLINIC DR DFORD, IN47421	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION DATE
	leading into the	pervisor, it was he aforementioned door Housekeeping room was th a self closing device on		residents were affected b lack of this door closure.  What measures will be p	
	the door.  3.1-19(b)	in a sen closing device on		place or what systemic changes you will make t ensure that the deficient practice does not recur?	
				Maintenance Supervisor/Designee will responsible to ensure cor and proper function throu scheduled rounds.	npliance
				How the corrective action will be monitored to enso deficient practice will not i.e., what quality assurate program will be put into	ure the ot recur, nce
				Maintenance Supervisor/Designee will responsible to ensure cor and proper function throu scheduled rounds each th days for a period of ninety These rounds will be revie the facility Quality Assura Program for potential acti follow-up.	npliance gh nirty / days. ewed by nce
				This Plan of Correction constitutes our credible allegation of compliance all regulatory requireme Our date of completion i 1/6/12	nts.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	01	COMPL	ETED
		155135	A. BUII B. WIN			12/20/2	011
			b. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LINIC DR		
WESTVIE	EW NURSING AND	REHABILITATION CENTER		BEDFORD, IN47421			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0048		plan for the protection of all eir evacuation in the event					
SS=E	of an emergency.						
	Based on record review and interview, the facility failed to include the use of kitchen		K	0048	K-048 The use of fire extinguisher	s	01/06/2012
			'``	70 10	in relationship with the use of the		01/00/2012
	•	s in 1 of 1 written fire			kitchen overhead extinguishing		
	•				system.		
		he facility in the event of			Facility failed to include the	•	
	• •	SC 19.2.2.2 requires a			use of kitchen fire		
		re occupancy fire safety			extinguishers in 1 of 1 writt		
	-	ovide for the following:			plans for the facility in the case of an emergency.		
	(1) Use of alarms				or all emergency.		
	(2) Transmission of alarm to the fire department				What corrective actions will	l be	
					accomplished for these		
	(3) Response to a	alarms			residents found to have been	en	
	(4) Isolation of fi	ire			affected by the deficient		
	(5) Evacuation of	f immediate area			practice?		
	(6) Evacuation of	f smoke compartment			The emergency plan now		
	(7) Preparation o	f floors and building for			includes a written description	of	
	evacuation	_			the use of kitchen fire		
	(8) Extinguishme	ent of fire			extinguishers in conjunction		
		actice affects any			the overhead fire extinguishe	er	
	•	as staff and visitors in the			system.		
	vicinity of the kit				How will you identify other		
	vicinity of the Kit	ienen.			residents having the potent	ial	
	Findings include:				to be affected by the same		
	rindings include	•			deficient practice and what		
	Danadan a maria				corrective action will be tak	en?	
		w of the facility's written			O45 Did- (		
	-	on 12/20/11 at 4:45 p.m.			Other Residents were identifi as any resident in the vicinity		
		ance Supervisor the fire			the kitchen. The emergency		
	•	not include the use of			now includes a written descri		
		ass fire extinguishers			of the use of kitchen fire		
		chen in relationship with			extinguishers in conjunction		
	the use of the kite	chen overhead			the overhead fire extinguishe	er	
	extinguishing sys	stem. Based on an			system.		
			ı				

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	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  1510 CLINIC DR  BEDFORD, IN47421				
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K0070 SS=E	interview on 12/2 the Maintenance acknowledged th for the facility di the ABC or K cla 3.1-19(b	20/11 at 4:50 p.m. with Supervisor it was e written fire safety plan d not include mention of ass fire extinguishers.		TAG	What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?  Maintenance Supervisor/Designee will be responsible to ensure complit through scheduled rounds.  How the corrective action(swill be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into plate Maintenance Supervisor/Designee will be responsible to ensure complithrough scheduled rounds eathirty days for a period of ninedays. These rounds will be reviewed by the facility Quality Assurance Program for potentiation or follow-up.  This Plan of Correction constitutes our credible allegation of compliance will regulatory requirements. Our date of completion is: 1/6/12	ance ) the ecur, ce? ance ach ety tty ntial	DATE
		nts of such devices do not es F. (100 degrees C)					

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	PROVIDER OR SUPPLIER	REHABILITATION CENTER		1510 C	ADDRESS, CITY, STATE, ZIP CODE LINIC DR DRD, IN47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	Based on observed facility failed to for the use of 1 coused in nonsleep deficient practice observed standing Business Managhall as well as via Findings included Based on observed p.m. with the Mathematical Based on observed p.m. with the Mathema	ation and interview, the provide documentation of 1 portable heating units ing staff areas. This is could affect 5 residents ag in the hall next the the er's office on Main front sitors and staff.  ation on 12/20/11 at 1:15 intenance Supervisor, the text to the Administrative all front contained one eater which was not time, but documentation is to verify the heating exceed two hundred and at Based on interview on 7 p.m. with the	K	TAG	K-070 Portable space heaters in staff areas Facility failed to provide documentation for the use of 1 portable heating units used in a non-sleeping staff area.  What corrective actions will accomplished for these residents found to have be affected by the deficient practice?  The portable heating unit has been removed from the facilit How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taken to be affected by the same deficient practice and what corrective action will be taken to be affected by the same deficient practice. The portable heating unit has been removed from the facility.  What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur?  Maintenance Supervisor/Designee will be responsible to ensure complithrough scheduled rounds. Shas been educated that no	I be en s tty. tial cen? Tied r of table red into	DATE 01/06/2012
					portable heating units are		

000060

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED
		155135	B. WING		12/20/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
		REHABILITATION CENTER	BEDFC	LINIC DR DRD, IN47421	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
		,		permissible in the facility.	
				How the corrective action(s will be monitored to ensure deficient practice will not row i.e., what quality assurance program will be put into plate Maintenance Supervisor/Designee will be responsible to ensure complethrough scheduled rounds exthirty days for a period of nindays. These rounds will be reviewed by the facility Qual Assurance Program for pote action or follow-up.  This Plan of Correction constitutes our credible allegation of compliance wall regulatory requirements Our date of completion is: 1/6/12	e the ecur, e ace?  iance ach eety  ity ntial

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  01		X3) DATE SURVEY  COMPLETED					
		155135	B. WINC	3 <u> </u>		12/20/2	011
NAME OF PROVIDER OR SUPPLIER WESTVIEW NURSING AND REHABILITATION CENTER				1510 CL	DDRESS, CITY, STATE, ZIP CODE INIC DR RD, IN47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0074 SS=E	and other loosely berving as furnishicare occupancies provisions of 10.3. for the Installation Shower curtains a 701.  Newly introduced health care occupa specified when tesmethods cited in 119.7.5.1, NFPA 13.  Newly introduced specified when tesmethod cited in 10. Based on observatinterview; the fact flame resistant decurtains in 2 of 4. Northeast hall. Toculd affect 8 resand staff.  Findings include  Based on observational staff.  Findings include	mattresses meet the criteria sted in accordance with the 1.3.2 (3), 10.3.4. 19.7.5.3 action, record review and cility failed to provide ocumentation for window resident rooms on This deficient practice sidents as well as visitors  ations on 12/20/11 from 12.5.5.  the p.m. with the pervisor, the window in resident rooms 34 and and documentation were inherently flame	K0	074	K-074 Non-flame resistant curtain hanging in resident rooms Facility failed to provide flar resistant documentation for window curtains in 2 of 4 resident rooms  What corrective actions will accomplished for these residents found to have been affected by the deficient practice?  Curtains lacking fire resistant documentation have been removed from the facility.  How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taken.	me I be en	01/06/2012

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	(X3) DATE COMP: 12/20/2	LETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	1510 C	ADDRESS, CITY, STATE, ZIP COE LINIC DR DRD, IN47421	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE ROPRIATE	(X5) COMPLETION DATE
		egarding flame retardancy curtains and the curtains		Other Residents were ideas any resident in the value the business office. The heating unit has been refrom the facility.	icinity of e portable	
	3.1-19(b)			What measures will be place or what systemic changes you will make ensure that the deficie practice does not recu	e to nt	
				Maintenance Supervisor/Designee w responsible to ensure c through scheduled rour has been educated that heating units are not pe in the facility.	ompliance nds. Staff t portable	
				How the corrective act will be monitored to er deficient practice will i.e., what quality assur program will be put int	nsure the not recur, rance	
				Maintenance Supervisor/Designee w responsible to ensure of through scheduled rour thirty days for a period of days. These rounds wi reviewed by the facility Assurance Program for action or follow-up.	ompliance nds each of ninety Il be Quality	
				This Plan of Correction constitutes our credib allegation of complian	le	

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  All regulatory requirements.  Our date of completion is:  1/6/12  K0144  SS=F  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.  3.4.4.1.		NT OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135	(X2) MU A. BUII B. WING	LDING	NSTRUCTION  01	(X3) DATE S COMPLE 12/20/20	ETED
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  K0144 SS=F  Regulatory are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.  3.4.4.1.  Based on record review and interview, the facility failed to document the alternate source of power from the generator was capable of automatically connecting to load within 10 seconds for the last 12 of  PREFIX TAG RECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  REQUILATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG RECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY.)  All regulatory requirements.  Our date of completion is:  1/6/12  K-144 Failure to document  generator connecting within 10 seconds.  Facility failed to document the alternate source of power from the generator was capable of	WESTVIEW NURSING AND REHABILITATION CENTER			1510 CLINIC DR				
K0144 SS=F  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to document the alternate source of power from the generator was capable of automatically connecting to load within 10 seconds for the last 12 of  Our date of completion is: 1/6/12  K-144 Failure to document generator connecting within 10 seconds. Facility failed to document the alternate source of power from the generator was capable of	PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
the generator was supusion		exercised under lo month in accordar 3.4.4.1. Based on record facility failed to source of power capable of autom	review and interview, the document the alternate from the generator was natically connecting to	K0	0144	Our date of completion is: 1/6/12  K-144 Failure to document generator connecting within 10 seconds.  Facility failed to document	the	01/06/2012
Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-6.3.1.2 requires the emergency system to be arranged so, in the event of failure of the normal power source, the alternate source of power will automatically connect to load within 10 seconds. This deficient practice could affect all occupants in the facility as well as visitors and staff if it could not be assured all residents were safeguarded by the facility with a generator which would operate under load conditions when needed during a power failure.  Based on review of Generator Log records on 12/20/11 at 3:30 p.m. with the		load within 10 set 12 months. NFP Health Care Faci requirements req distribution systems as describing the emergency systems as describing the emergency system automatically conseconds. This deaffect all occupant as visitors and stransfer automatically with a operate under loan needed during a principle.	econds for the last 12 of PA 99, the Standard for illities, Nursing Home quires essential electrical ems to conform to Type 2 libed in Chapter 3 of PA 99, 3-6.3.1.2 requires ystem to be arranged so, ailure of the normal power nate source of power will efficient practice could ents in the facility as well eaff if it could not be ents were safeguarded by a generator which would ad conditions when power failure.			the generator was capable of automatically connecting to load within 10 seconds.  What corrective actions will accomplished for these residents found to have been affected by the deficient practice?  All residents could be affected this issue. The regular testing that had been completed durn this time period will now be documented to ensure a recorproof that the generator is connecting to load within 10 seconds.  How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taked. All residents could be affected this issue. The regular testing the product of the regular testing the product that the regular testing the product of the potent to be affected by the same deficient practice and what corrective action will be taked.	of D I be en ed by ing ord of tial ed by	
Maintenance supervisor, the number of this time period will now be  FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: S81121 Facility ID: 000060 If continuation sheet Page 17 of 21	EODM CMS 2			004404	Equility: 1	this time period will now be		- 47 of 04

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135		LDING	NSTRUCTION 01	(X3) DATE COMPL <b>12/20/2</b>	ETED
NAME OF PROVIDER OR SUPPLIER WESTVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1510 CLINIC DR  BEDFORD, IN47421				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	seconds for the g was not documen on 12/20/11 at 3: Maintenance Sup acknowledged th load transfer had past twelve mont	enerator to transfer load nted. Based on interview 33 p.m. with the		TAG	documented to ensure a recorproof that the generator is connecting to load within 10 seconds.  What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur?  Maintenance Supervisor/Designee will be responsible to ensure complithrough scheduled testing of generator.  How the corrective action(s will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into plate.  Maintenance Supervisor/Designee will be responsible to ensure complithrough scheduled testing documentation each thirty days testing documentation will be	into  ance the  the  ace?  ance pys	DATE
					reviewed by the facility Quali Assurance Program for poter action or follow-up.	ty	
					This Plan of Correction constitutes our credible allegation of compliance wi all regulatory requirements Our date of completion is:		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155135		A. BUII	A. BUILDING 01 CO B. WING 12/		(X3) DATE ( COMPL 12/20/2	ETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	Ī	1510 CI	ADDRESS, CITY, STATE, ZIP CODE LINIC DR DRD, IN47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0154 SS=C	is out of service fo 24-hour period, the jurisdiction is notification is notificated or an axis provided for all providing and containing procedure event the autohas to be placed of the event the autohas to be notified of a second or and the evacuation or and the eva	ed, and the building is pproved fire watch system parties left unprotected by the sprinkler system has ervice. 9.7.6.1 review and interview, the protect 75 of 75 residents omplete written policy dures to be followed in omatic sprinkler system out of service for more 24 hour period in LSC, Section 9.7.6.1. irres sprinkler impairment by with NFPA 25, section, Testing and Water Based Fire ms. NFPA 25, 11-2 inted sprinkler dinator. NFPA 25, 11-5 nned program to include approved fire watch and the local fire department prinkler impairment and the insurance carrier, building owner/manager ties having jurisdiction and 11-5(f) requires pervisors in the area in already mentioned and res notification of	S81121	Facility	K-154 Notifying all entities after sprinkler system has been restore Facility failed to provide documentation that all appropriate entities would notified when the sprinkler system had been restored, had experienced a failure.  What corrective actions will accomplished for these residents found to have be affected by the deficient practice?  All residents could be affected. The plan now includes instrutto notify listed, appropriate entities following the restoring the sprinkler system should in experience a failure.  How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taken all residents could be affected. The plan now includes instruction notify listed, appropriate entities following the restoring to notify listed, appropriate entities following the restoring the continuation of the contin	be  if it  I be en  ed. ection g of t  tial  ed. ection g of	01/06/2012 ae 19 of 21

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155135		LDING		12/20/2011	
			B. WIN		DDDEGG CITY OT TE ZID CORE	12.20.2011	
NAME OF P	PROVIDER OR SUPPLIER	-			DDRESS, CITY, STATE, ZIP CODE		
\\/EQT\/II	EW NILIDSING AND	REHABILITATION CENTER			LINIC DR RD, IN47421		
				l			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	,	(5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	the sprinkler system should i	DA'	IE
	, ,	when the system is			experience a failure.	'	
		eficient practice could					
	affect all resident	ts, staff and visitors.			What measures will be put	into	
					place or what systemic		
	Findings include	:			changes you will make to		
					ensure that the deficient		
	Based on Sprinkl	ler record review on			practice does not recur?		
	12/20/11 at 4:05	p.m. with the			Maintenance		
	Maintenance Sur	pervisor, the facility did			Supervisor/Designee will be		
	_	olicy and procedure for an			responsible to ensure compl		
	impaired sprinkle	er system available for			through following the item ac		
		not address notifying all			to the plan to make notification	on	
	•	ce the sprinkler system			following the restoring of the sprinkler system, should it ev	ver	
	_	l to normal. Based on			fail.		
		20/11 at 4:06 p.m. with					
		Supervisor, it was					
		-			How the corrective action(s	·	
	_	e fire watch policy did			will be monitored to ensure		
		ying all entities again			deficient practice will not re		
	_	r system had been			i.e., what quality assurance program will be put into pla		
	restored to norma	al operation.			program will be put into pic		
					Maintenance		
	3.1-19(b)				Supervisor/Designee will be		
					responsible to ensure compl	ance	
					through ongoing, scheduled	nev	
					rounds and review of emergor plans. These rounds will be	ысу	
					reviewed by the facility Quali	ty	
					Assurance Program for pote	•	
					action or follow-up.		
					This Plan of Correction		
					constitutes our credible		
					allegation of compliance w	th	
					all regulatory requirements		
					Our date of completion is:		
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID: S	 81121	Facility I	D: 000060 If continuation s	heet Page 20 o	f 21

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
WESTVIEW NURSING AND REHABILITATION CENTER				CLINIC DR DRD, IN47421	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
		,		1/6/12	